1. Medicaid Overview

Title XIX of the Social Security Act is a medical assistance program for certain medically needy and low income individuals and families known as "Medicaid." The Medicaid Program in North Carolina is administered by the Division of Medical Assistance (DMA) in Raleigh. DMA contracts with Electronic Data Systems (EDS) to process Medicaid claims for payment and to perform a variety of other administrative tasks.

Medicaid covers a wide variety of services. The policies and procedures for coverage, specific to the type of service offered by the provider, is given to providers upon enrollment and at provider workshops. Updated coverage information and notice of changes are issued in monthly Medicaid Bulletins or as replacement pages for provider manuals.

1.1 Medicaid Eligibility

Medicaid eligibility for most recipients is determined by the county department of social services (DSS) in the county in which the individual resides. Applicants for Medicaid are evaluated on income level, available financial resources, and criteria related to categorical standards.

Aged, blind and disabled individuals who receive Supplemental Security Income (SSI) are automatically entitled to North Carolina Medicaid benefits and are not required to make a separate Medicaid application at the county DSS office. SSI eligibility is determined by the Social Security Administration.

North Carolina Medicaid recipients receive benefits in the following assistance categories:

- Medicaid-Aid to Families with Dependent Children (MAF);
- Medicaid-Aid to the Aged (MAA);
- Medicaid-Aid to the Blind (MAB);
- Medicaid-Aid to the Disabled (MAD);
- Medicaid-Infants and Children (MIC);
- Medicaid-Pregnant Women (MPW);
- Medicaid-Qualified Medicare Beneficiaries (MQB);
- Medicaid-Special Assistance to the Blind (MSB);
- Medicaid-Refugees (MRF);
- Refugee Assistance (RRF);
- Special Assistance-Aid to the Aged (SAA);
- Special Assistance-Aid to the Disabled (SAD); and
- Foster Care; Adoption Subsidy (HSF, IAS).

For general questions on eligibility, contact the county department of social services.

1.2 When Eligibility Begins

An individual is eligible for Medicaid the month in which he meets all categorical and financial conditions of eligibility. If all requirements are met on the first day of the month, eligibility begins that day. If the recipient has a deductible or excess reserve and all other conditions are met, he is eligible on the day of the month that he meets his deductible or reduces his reserve to the allowable limit. The Medicaid deductible is met by incurring medical expenses which the individual is responsible for paying from his own funds during the certification period in which he requests assistance.

1.3 Retroactive Eligibility

Retroactive coverage may be approved for up to three months prior to the month of the application if the applicant meets all eligibility conditions in the retroactive period and has unpaid medical bills for any one of the three months prior to application. Medicaid will pay for covered services received during the retroactive period provided all other Medicaid guidelines are met. Providers may choose to accept or not accept retroactive eligibility.

1.4 Medicaid Identification (MID) Cards

Individuals approved for Medicaid receive a monthly Medicaid identification (MID) card as proof of their eligibility. The MID card contains information necessary for claims filing, including the recipient MID number, date of birth, insurance information, other eligible family members, and eligible dates for which the card is valid. Since the recipient's eligibility may change from month to month, MID cards are replaced at the beginning of each month. The new card will show valid eligible dates only through the current calendar month. Providers must ask recipients to present their MID card as proof of eligibility for the dates of services rendered.

MID cards may vary in color based on eligibility conditions of the recipient. A blue MID card indicates the recipient is eligible for all Medicaid services for which he meets the service coverage requirements. A pink MID card indicates the recipient is eligible for pregnancy related services. A buff MID card indicates the recipient is eligible for the Medicare-Aid program, whereby if Medicare covers a service, Medicaid will pay the co-insurance and/or deductible on the service.

1.5 Verifying Eligibility Status

If a recipient loses eligibility, he is sent written notice at least ten working days before eligibility ends. Eligibility ends on the last day of the month except when the recipient dies or when a pregnant woman presumed eligible is determined ineligible by a department of social services. If the recipient says he did not receive his MID card in the mail, ask if he received a notice about a change in his eligibility status and the nature of the change. You may use the EDS Voice Inquiry System to verify the patient's eligibility for the date of service. The telephone number for EDS Voice Inquiry System is listed in Appendix C.

Recipients who present for services without proof of insurance or Medicaid coverage may be expected to pay for the services received. Since individuals and families who are Medicaid eligible have incomes ranging from as low as 34% of poverty up to 185% of poverty, most would not have the financial means to pay for care. You are urged to enforce the need for patients to bring their MID cards when they present for services and to use the EDS Voice Inquiry System to verify eligibility for recipients. When eligibility cannot be verified for a particular date of service, the recipient may be held fully responsible for all charges